DCAP DEPENDENT CARE ASSISTANCE PROGRAM

SALARY REDUCTION AGREEMENT

STATE OF WASHINGTON
DEPARTMENT OF RETIREMENT SYSTEMS

P.O. Box 40931 • Olympia, WA 98504-0931 • www.drs.wa.gov

For questions, please call DCAP customer service at 360-664-7005 (in the Olympia area) or toll-free at 1-800-423-1524 and select option 4.

Please type or print in dark ink. Return completed form to DRS.

Please check the appropriate box(es) for all changes:

☐ OPEN ENROLLMENT ☐ NEW EMPLOYEE ☐ STATUS CHANGE/EFFECTIVE DATE _____

Change in family status (May require additional information)

☐ 1. MARRIAGE
☐ 2. DIVORCE OR LEGAL SEPARATION
☐ 3. DEATH OF SPOUSE/DEPENDENT
☐ 4. ADDITION OF DEPENDENT
☐ 5. TERMINATION OF EMPLOYMENT OF SPOUSE
☐ 6. EMPLOYMENT OF UNEMPLOYED SPOUSE
☐ 7. SUBSTANTIAL CHANGE IN EMPLOYMENT HOURS
☐ 8. CHANGE IN PROVIDER
☐ 9. CHANGE IN DEPENDENT CARE/PROVIDER COSTS
☐ 10. NO LONGER USE DEPENDENT CARE SERVICES
☐ 11. TERMINATION FROM STATE SERVICE

Section One: Personal Information

1. Name _____
☐ Change Last First M.I.

2. SSN _____

3. Address _____
☐ Change Number Street

4. Work Phone _____

_____
City State Zip

5. Home Phone _____

6. Current Employer _____

Married Yes ◯ No ◯

E-mail Address _____

7. List qualifying dependents below:

Last	First	M.I.	Date of Birth

8. If higher education employee, circle the number of months paid: ◯ ◯ ◯ ◯ Not Applicable ◯

9. Annual Earned Income	10. Spouse Annual Earned Income	11. Per Pay Period Reduction	12. Total Annual Reduction 20___
$	$	$	$

Section Two: Authorization

I authorize payroll to deduct the amount set forth in Section One, Box 12 for the plan year and to transmit this amount in equal installments to the Department of Retirement Systems for the Dependent Care Assistance Salary Reduction Program. This agreement supersedes any prior agreement and will continue until further notification as set forth in the Plan. I acknowledge I have read and understand all sections of the "DCAP Memo of Understanding" on the reverse side of this agreement.

X _____ _____
Signature of Employee Date

Reset Form

Section Three: FOR DCAP USE ONLY

1. AGENCY NUMBER	2. SUB. AGENCY NUMBER	3. PAY PERIODS REMAINING IN PLAN YEAR
4. EFFECTIVE MONTH	5. REDUCTION BEGINNING DATE	6. REDUCTION PER PAY PERIOD

DCAP DEPENDENT CARE ASSISTANCE PROGRAM

DCAP MEMO OF UNDERSTANDING

STATE OF WASHINGTON
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THIS MEMO ONLY HIGHLIGHTS THE EMPLOYEES' DEPENDENT CARE ASSISTANCE SALARY REDUCTION PROGRAM. YOU SHOULD REFER TO A COPY OF THE PROGRAM REGULATIONS FOR SPECIFIC DETAILS.

I UNDERSTAND the following:

1. Enrollment is required for each plan (calendar) year (WAC 415-600-110 and WAC 415-600-210).

2. My gross salary will be reduced each regular pay period by an equal fraction of the total salary reduction amount that I have elected (WAC 415-600-280). This amount should not exceed my earned income and should not exceed the earned income of my spouse (WAC 415-600-250 and WAC 415-600-260).

3. My election may not be terminated or modified during the plan year except in the case of a “qualifying change in status” (WAC 415-600-240).

4. My dependent care account will be used to reimburse only eligible dependent care expenses for services incurred during the plan year (WAC 415-600-110 and 415-600-310).

5. Services must occur on days I work and if married, on days my spouse works; or if my spouse is a full-time student, services must occur on days my spouse attends school (WAC 415-600-310).

6. Only expenses directly related to the care or supervision of qualifying person(s) may be claimed for reimbursement (WAC 415-600-110 and 415-600-310).

7. Qualifying person(s) must be under 13 years of age, or physically and/or mentally incapable of self-care and spend at least 8 hours each day in my household (WAC 415-600-110 and 415-600-310).

8. If my provider is a child of mine, she/he must not be an IRS dependent and must be at least age 19 as of the close of the plan year (WAC 415-600-310).

9. Any amounts remaining in my dependent care account after all timely claims have been submitted will be forfeited to the State of Washington (WAC 415-600-020 and 415-600-440).

10. Funds in my dependent care account belong to the State of Washington until paid to me under the terms of the Program. I realize that I may not assign or transfer my rights in the Program (WAC 415-600-610).

11. As a result of reducing my gross income, my social security benefit may be lower (WAC 415-600-020).

12. My salary reduction amount may be reduced at any time to assure that the Dependent Care Assistance Program satisfies existing or future anti-discrimination requirements of the Internal Revenue Code (WAC 415-600-270).

13. The State of Washington retains control over all aspects of the Program including the right to amend or terminate the Program (WAC 415-600-290).

14. Neither the Department nor the State of Washington makes any commitment or guarantee that any amount paid to or for the benefit of a participant will be excludable from the participant’s gross income for federal or state income tax purposes (WAC 415-600-630).

I ACKNOWLEDGE THAT I HAVE RECEIVED AND REVIEWED A COPY OF THE DEPENDENT CARE ASSISTANCE PROGRAM REGULATIONS. I FURTHER ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ALL SECTIONS OF THE “DCAP MEMO OF UNDERSTANDING.”